Medicaid Benchmark Options Analysis

Washington Health Care Authority
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manatt

Overview

- Legal Requirements for Medicaid Benchmark
- Open Policy Questions
- Washington Considerations for Designing Medicaid Benchmark

Legal Requirements for Medicaid Benchmark

New Adult Eligibility Group Receives Benchmark Coverage

ACA establishes new, mandatory Medicaid eligibility group of non-pregnant adults between 19-65 with incomes ≤133% FPL

- This "new adult eligibility group" consists of childless adults, and parents/caretakers above state's 42 CFR 435.110 level
- States must provide Benchmark or Benchmark-equivalent coverage described under §1937 of the Social Security Act (DRA), as modified by the ACA to adults in new adult eligibility group
- States will receive enhanced FMAP for "newly eligibles" within new adult eligibility group

Most Medicaid Beneficiaries Receive Standard Benefits

The Social Security Act §1905(a) describes mandatory benefits that states ***must*** cover as well as optional benefits states ***may*** cover

Standard Medicaid Benefits	
Mandatory Services	**Common Optional Services (# of states covering)**
Inpatient and outpatient hospital care	Prescription drugs (50)
Physicians' services	Clinic services (50)
EPSDT for individuals covered in State's Medicaid program under 21	SNF services for individuals under 21 (50)
Family planning services and supplies	Occupational therapy (50)
FQHC and RHC services	Targeted case management (50)
Home health services	Physical therapy (50)
Laboratory and X-ray	Hospice (48)
Nursing facility services	Inpatient psychiatric for individuals under 21 (48)
Nurse midwife and nurse practitioner services	Services for individuals with speech, hearing, and language disorders (45)
Tobacco cessation counseling and pharmacotherapy for pregnant women	Audiology services (43)
Non-emergency transportation	Personal care (35)
Freestanding birth center services	Rehabilitative services (includes mental health and substance use services) (33)

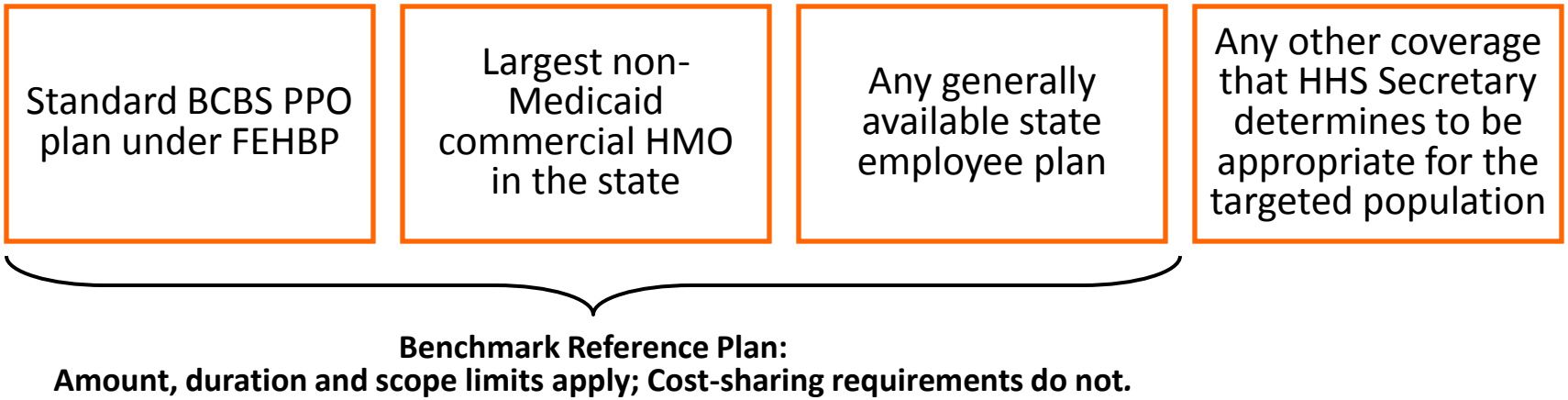
Source: MACPAC Report to the Congress on Medicaid and CHIP, Chapter 2, Table 2-1 (March 2011)

Benchmark Coverage Under Deficit Reduction Act (DRA)

- Since 2006, DRA has provided state option to tailor Medicaid coverage through
  - Benchmark coverage or
  - Benchmark-equivalent coverage
- May be provided to sub-populations or geographic regions
  - No state-wideness/comparability requirements
  - May be tailored for special populations
- Must be provided in accordance with principles of economy and efficiency

Benchmark Coverage under the DRA

- Benchmark coverage linked to:



- Benchmark must cover:
  - EPSDT for any child under age 21 covered under the state plan
  - FQHC/RHC services
  - Non-emergency transportation
  - Family planning services and supplies
- State may supplement benefits in Benchmark reference plan

Benchmark and Standard Coverage: Both Subject to Cost-sharing Rules In §§1916 & 1916A

- Certain groups exempt from cost-sharing: Pregnant women, children under age 18
- Certain services exempt from cost-sharing: emergency services, family planning
- Only nominal co-pays allowed for those with income ≤ 100% FPL
- Premiums prohibited for individuals with income ≤ 150% FPL
- All cost-sharing subject to aggregate cap of 5% family income

Maximum allowable Medicaid Premiums and Cost-Sharing			
	≤ 100% FPL	≤ 150% FPL	Above 150% FPL
Aggregate cap	5% family income	5% family income	5% family income
Premiums	Not allowed	Not allowed	Allowed
Deductibles	Nominal	Nominal	Nominal
Maximum service-related co-pays/co-insurance			
Most services	Nominal	10% of cost	20% of cost
Non-emergency ER	Nominal	2x nominal	No limit, but 5% aggregate cap applies
Rx drugs	Nominal	Nominal	Nominal (preferred) 20% of cost (non-preferred)

Individuals Exempt from Mandatory Benchmark Enrollment

- Pregnant women
- Individuals who qualify for Medicaid based on being blind or disabled (regardless of SSI eligibility)
- Dual eligibles
- Terminally ill hospice patients
- Inpatients in hospitals, nursing home and ICF who must spend all but a minimal amount of their income for the cost of medical care
- TANF/Section 1931 parents and caretakers
- Medically frail individuals, including those with disabilities that impair ability in one or more activities of daily living
- Children in foster care
- Individuals who qualify for LTC services based on their medical condition
- Individuals who only qualify for emergency care
- Individuals who qualify based on spend down

Optional Benchmark Enrollment

- State may offer Benchmark exempt individuals the option to enroll in Benchmark
- State must advise Benchmark-exempt individual that
  - enrollment is voluntary and
  - individual may dis-enroll into standard benefits at any time
- State must provide Benchmark-exempt individuals a comparison of Benchmark benefits and cost sharing

ACA Changes to Benchmark: Essential Health Benefits (EHBs)

Beginning in 2014, Benchmark must include all EHBs for:

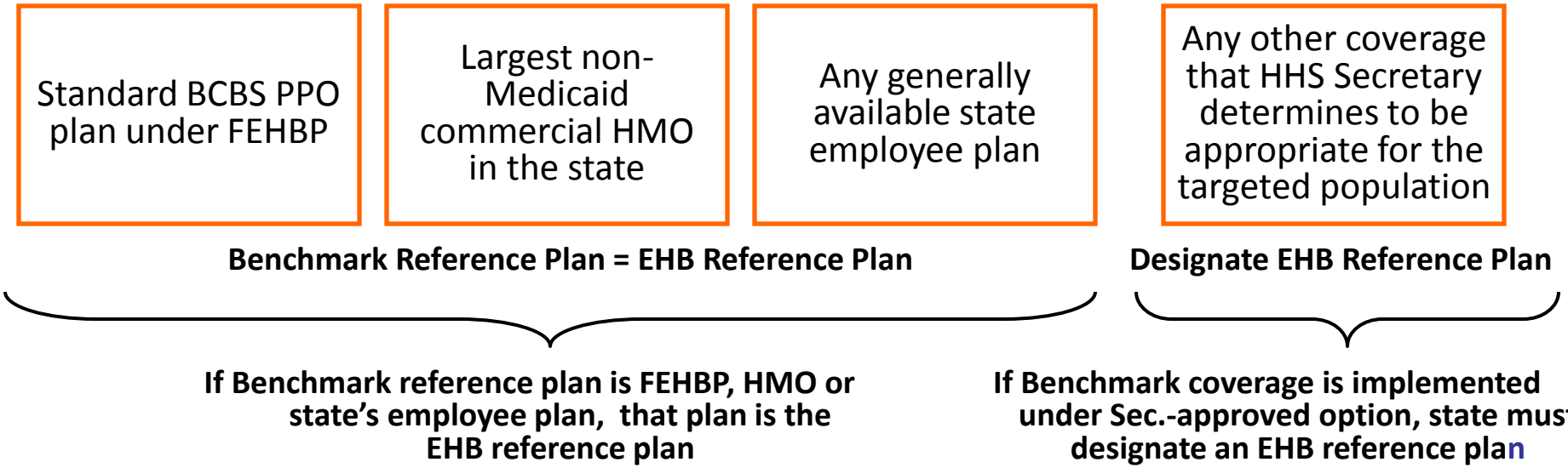
- new adult eligibility group (newly-eligible and currently-eligible)
- all existing Benchmark populations

EHB Categories:

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

EHBs and Medicaid Benchmark Coverage

- State must identify an EHB reference plan for its Medicaid Benchmark
- If EHB reference plan does not cover all required EHBs, state must supplement



EHBs and Medicaid Benchmark Coverage (Ctd)

- EHB reference plan for Medicaid may be different than EHB reference plan for individual and small group market (Regence Innova)
- State may select its standard Medicaid package as its Benchmark coverage under "Secretary-approved" option
  - Still need an EHB reference plan
- State must specify EHB reference as part of 2014-related Medicaid State Plan changes
- States must provide public notice and reasonable opportunity to comment ***before*** submitting Benchmark plans to CMS

Unlike in individual and small-group market:

- State may have more than one Benchmark for new adult group
- No default reference plan – State must choose
- No substitution of benefits within or across EHB categories

ACA Changes to Benchmark: Mental Health Parity

- Under current law, federal mental health parity (FMHP) requirements only apply to Medicaid managed care, not Medicaid fee-for-service.
- The ACA expands some FMHP requirements to all Benchmark and Benchmark equivalent plans
  - Mental health and substance abuse benefits must have parity with medical/surgical benefits with respect to:
    - Financial requirements (deductibles, co-pays, and coinsurance)
    - Treatment limitations (frequency/scope/duration)
  - Because Benchmark must cover EPSDT, it meets FMHP requirements for individuals under 21

Option to Provide Long Term Care (LTC) for New Adult Eligibility Group

- States may define Benchmark to include LTC services for some or all in new adult eligibility group
  - Those receiving LTC services in new adult eligibility group retain their MAGI status and MAGI methodologies apply (e.g. no resource test)
  - Post-financial eligibility rules for institutional care would still apply
- Adults in new adult eligibility group do not include:
  - Individuals who request coverage for LTC services "for purposes of being evaluated for an eligibility group under which long term care services and supports are covered."
  - Individuals receiving SSI
  - Individuals > 65 years old
  - Individuals whose eligibility is based on being blind or disabled
  - Individuals under express lane

Open Policy Questions

Open Questions: Benchmark Exemptions

- Do the Benchmark exemptions in Section 1937(a)(2)(B) apply to the new adult eligibility group?
- Will states receive enhanced FMAP for providing services to individuals in the new adult eligibility group who fall within a Benchmark exempt category?

Open Questions: Institution for Mental Diseases Exclusion

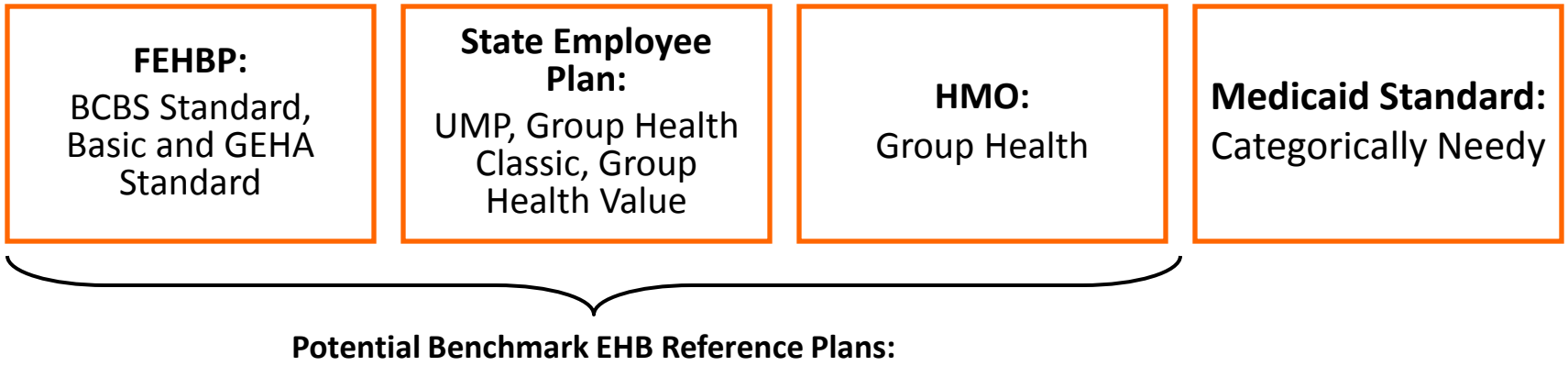
- Medicaid does not cover services provided to beneficiaries between the ages of 21 and 65 who are patients of Institutions for Mental Diseases (IMD).
- EHBs include mental health and substance use services and mental health parity applies to Benchmark.
- If a state selects an EHB reference plan that includes IMD services, may or must the state include such services in its Benchmark and will the state receive FMAP for covering them?

Open Questions: Relationship between EHB Reference Plan and Medicaid Benchmark

- May states include in their Benchmark services not listed in Section 1905(a) as either a mandatory or optional benefit?
  - §1915(i) Home and Community-Based Services
  - §1915(j) Self-Directed Personal Assistant Services
  - §1915(k) Community First Choice
  - §1945 Health Home Services
- If federal Medicaid law does not cover a type of service (e.g., infertility treatment) and such service is included in the EHB reference plan, may or must the service be covered in Benchmark?
- If federal Medicaid law does not cover a type of setting/provider (e.g., free-standing residential detox facilities) and such setting/provider is included in the EHB reference plan, may or must the setting/provider be covered in Benchmark?
- If the EHB reference plan covers Medicaid optional services that the State does not cover in Standard, must Medicaid Benchmark cover these services?
- If the EHB reference plan covers state mandates that otherwise do not apply to Medicaid, may or must Medicaid Benchmark cover these state mandates?
- How will mental health parity be implemented in Benchmark?

Considerations for Designing Washington's Medicaid Benchmark Benefit

Comparison of Washington Medicaid Standard and Potential EHB Reference Plans



- Methodology:
  - Compared benefits across potential EHB Reference Plans and Medicaid Standard
  - Identified meaningful differences in coverage
  - Noted where State may be required to include EHB-covered service in Benchmark and differences with current Medicaid Standard

Overview of Findings

- Significant alignment of covered services in EHB Reference Plans and in Medicaid Standard with some notable exceptions:
  - EHB Reference Plans cover some services and providers not currently offered under Medicaid Standard
  - EHB Reference Plans cover more visits in some services than currently offered under Medicaid Standard
  - Medicaid Standard offers more visits/days in some services than currently offered under EHB Reference Plan

EHB Benchmark Reference Plans Cover Services Not Currently Covered Under Medicaid Standard

- Chiropractic services
- Acupuncture services
- Naturopath services
- Lactation consultant services
- Massage therapy (medically necessary)
- Biofeedback for head-aches (if State Employee Plan is chosen)
- Eyeglasses for adults
- Hearing aids for adults
- Osteoporosis screening
- Infertility diagnosis (if FEHB Plan is chosen)
  - Not a Medicaid mandatory or optional benefit

EBH Benchmark Reference Plan Covers Providers Not Currently Covered Under Medicaid Standard

- Institutions for Mental Diseases

EHB Benchmark Reference Plan Covers More Visits In Some Services Than Currently Covered by Medicaid Standard

- Physical therapy
- Occupational therapy
- Speech therapy
- Optometrist
- substance abuse detoxification
- psychiatry
- psychology
- clinical social worker
- professional counselor

For example, FEHB Reference plans cover 50-75 visits (depending on plan), State Employee Plans cover 60 visits and Medicaid covers 6 visits (may be increased through authorization process)

All substance abuse and mental health treatment subject to federal mental health parity

Medicaid Standard Covers More Visits/Days in Some Services Than Covered Under EHB Reference Plans

- Personal care
- Private duty nursing
- Home health services
- Skilled nursing facility

Different Categories Eligible for Different Benefit Packages

Medicaid Category	Standard Medicaid	Benchmark
Children	✓	
Pregnant Women	✓	
Low Income Families (LIF)	✓	
Aged, Blind, Disabled	✓	
Section VIII Adults		✓ (unless Benchmark exemptions apply to sub-population)

Take Aways

- Section VIII Benchmark beneficiaries must receive services not currently offered to Medicaid Standard beneficiaries
  - For example, a Section VIII childless adult will receive chiropractic services and will be eligible to receive more physical therapy visits than a pregnant woman would receive under current Medicaid Standard
- The benefit package an individual receives depends on their eligibility category
  - For example, a Low Income Family (LIF) parent is eligible for private duty nursing care because they are entitled to Medicaid Standard.
  - A parent with income greater than LIF eligibility levels and less than 138% FPL will not be eligible for private duty nursing care because they are entitled to Benchmark
- The Benchmark benefit package may look more like a QHP benefit package than Medicaid Standard

Additional Considerations in Benchmark Design for New Section VIII Adult Eligibility Group

- Clinical needs of the individuals covered under new adult eligibility group
- Alignment across Medicaid categories
- Alignment between Medicaid and QHP
- Administrative ease
  - For beneficiary
  - For state
- Whether and how to apply cost-sharing
  - Below 100% FPL
  - Above 100% FPL
- FMAP implications
  - States receive enhanced match for coverage provided to newly-eligibles
  - Populations in the new adult eligibility group who would have been eligible under another (pre-existing) eligibility category as of December 1, 2009 are not "newly-eligible" and therefore not eligible for the enhanced match
    - FMAP proxy will be designed to exclude the previously-eligible

Options in Designing Benchmark

- Align Benchmark to Standard
  - Add Benchmark benefits to Standard
  - Add Standard benefits to Benchmark
- Offer different Medicaid benefit packages to different eligibility groups
  - Benchmark to new adult group
  - Medicaid Standard to children, pregnant women, LIF parents and ABD
- Offer two Benchmark benefit packages to new adult group
  - Healthy adult benefit package
    - Does not include long term care services
  - Medically Frail benefit package
    - Fully aligns with Medicaid Standard and includes long term care services
    - Includes long term care services but doesn't fully align to Medicaid Standard
  - Note, if Benchmark exemptions apply to new adult group, then State will be required to offer Standard benefits (with LTC services) to medically frail adults

Thank You!

Deborah Bachrach
Manatt Health Solutions
dbachrach@manatt.com
212-790-4594

Kinda Serafi
Manatt Health Solutions
kserafi@manatt.com
212-790-4625